

**STATE COLLEGE AREA SCHOOL DISTRICT
STUDENT SERVICES
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION**

NAME OF SCHOOL _____ GRADE _____ TEACHER _____

NAME OF CHILD _____

LAST _____ FIRST _____ MIDDLE _____ BIRTHDATE _____ SEX _____

IMMUNIZATION STATUS:

****GIVE DATE OF LAST BOOSTER AND LAST TB TEST****

TRIPLE ANTIGEN(DPT) _____ MEASLES, MUMPS, RUBELLA _____

TETANUS-DIPHThERIA(DT) _____ MEASLES, MUMPS, RUBELLA BOOSTER _____

TETANUS TOXIOD _____ MEASLES BOOSTER _____

POLIO BOOSTER _____

VARICELLA VACCINE _____ TUBERCULIN TEST DATE _____

DEVICE: TINE _____ MANTOUX _____ RESULT _____

HEPATITIS B 1. _____ 2. _____ 3. _____

OTHER: _____

MEDICAL HISTORY: (GIVE SIGNIFICANT DETAILS, INCLUDING SERIOUS ILLNESS ALLERGIES, OPERATIONS, ACCIDENTS)

VARICELLA :

YES NO

DATE OF DISEASE _____
Month _____ Year _____

REPORT OF EXAMINATION: (ELABORATE BELOW ON POSITIVE FINDINGS)

B/P _____ PULSE _____ HEIGHT _____ WEIGHT _____ VISION R 20/ _____ L 20/ _____ +LENS
WEARS CORRECTIVE LENS YES NO

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL
GENERAL NUTRITION	<input type="checkbox"/>	<input type="checkbox"/>	GLANDS	<input type="checkbox"/>	<input type="checkbox"/>	SKELETON	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	HEART	<input type="checkbox"/>	<input type="checkbox"/>	POSTURE	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>
EARS	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	HEARING	<input type="checkbox"/>	<input type="checkbox"/>
NOSE AND THROAT	<input type="checkbox"/>	<input type="checkbox"/>	GENITALIA (MALE)	<input type="checkbox"/>	<input type="checkbox"/>	SCOLIOSIS (BENDING POSITION)	<input type="checkbox"/>	<input type="checkbox"/>
TEETH AND GINGIVA	<input type="checkbox"/>	<input type="checkbox"/>	NEURO MUSCULAR SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>			

IS THE CHILD UNDER TREATMENT? YES NO

SHOULD THIS CHILD HAVE RESTRICTIONS ON PLAY OR PHYSICAL EDUCATION ACTIVITIES? RECOMMENDATIONS:

WHAT OTHER RECOMMENDATIONS DO YOU WISH TO MAKE TO THE TEACHER OR SCHOOL NURSE WHICH MIGHT BE OF BENEFIT TO THIS CHILD FROM THE POINT OF VIEW OF EITHER PHYSICAL OR MENTAL HEALTH?

SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS	
PHYSICIAN'S PRINTED NAME	TELEPHONE	DATE OF EXAMINATION